AccuReview

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[Date notice sent to all parties]: April 19, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L 3-4 Epidural Steroid Injection with IV sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Orthopaedic Surgery with over 52 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was injured on the job on xx/xx/xx when she slipped and fell on some ice. She had significant back pain. CT scan of her thoracic spine showed transverse process fractures at L1 and L2 and possibly L3.

04-06-11: New Patient Consultation. CC: lower back pain that has radicular pain down the leg and into the toes. She has burning and numbness, particularly in the big toe. This occurs really just when she is walking and standing. She has been off work since the injury. Pain rated 5/10 and is aggravated with prolonged sitting, standing, and walking and is better when she lies down. Medications: Ultram and Flexeril. PE: Claimant has an antalgic gait favoring the left side. There is pain noted to palpation primarily at the base of the lumbar spine and just slightly in the left upper lumbar region. She has discomfort and significant limitations, however, in all 6 directions. She has hypersensitivity to sensory testing of the left anterolateral lower leg. ALR does aggravate her radicular complaints. DX: 1. Subacute low back pain with left leg radiculitis level surface fall, 2. Thoracolumbar pain with left-sided upper lumbar transverse process

fractures, non-displaced, 3. Lower rib contusion, 4. Obesity. Plan: Claimant has some underlying anterolisthesis at 4-5, likely sustained injury causing her radicular complaints. Recommend MRI imaging to assess this further and consider diagnostic/therapeutic injections in her leg pain fails to improve. Recommend PT to address low back pain, keeping her in neutral spine given her transverse process fractures at least for the next month. Recommend a back brace which is indicated for such spinous process fractures. Recommend sedentary duty for work restrictions without driving her bus until she is doing markedly better and hopefully off some of these medications. Return after the MRI.

04-19-11: MRI of the Lumbar Spine wo Contrast. Findings: MRI of the lumbar spine demonstrates suggestion of a mild scoliotic deformity with maintenance of the normal lumbar lordosis. No fracture is identified. There is a 3 mm of anterolisthesis of L4 in relation to L5. Multilevel disc desiccation changes, narrowing, and scattered endplate changes are present. Scattered disc bulges are additionally noted. Consus medullaris is appropriately positioned.

04-27-11: Follow-up. CC: low back and left leg pain. Claimant feels that PT is helping and she is tolerating light duty at work. She has not received her back brace yet and stated she is taking 1-2 hydrocodone a day. Her back pain is rated 7/10 and the leg pain is 5/10. She continues to have episodic stabbing pain down the back of the left leg particularly if she stands or walks and reported some left groin pain at times with walking. PE: She has a mildly antalgic gait slightly favoring the left side. Lumbar spine has stiffness and guarding in all directions. She has symmetrically diminished reflexes. ALR does aggravate her left posterior leg pain. DX: 1. Subacute low back with left leg radiculitis following level surface fall at work, 2.thoracolumbar pain with left-sided upper lumbar transverse process fractures, non-displaced, improving, 3. Lower rib contusion, 4. Obesity, 5. Grade 1 listhesis at L4-5 with displacement of the descending nerve roots secondary to facet spur and ligamentum flavum protrusion. Plan: Her left sided pain at L4-5 segment may very well be due to one of the descending nerve roots hung up at that level. In this case, we should consider a left L5 nerve root block for further diagnostic purposes if needed. Continue PT for continued improvement. Wean down and off of Vicodin. Continue with current work restrictions and reevaluate next month.

05-30-11: On-Call Note. The claimant has an ESI approximately two weeks ago and it did not provide her with any relief. She has had severe low back and bilateral buttock pain, with genuinely great amount of discomfort. She is taking Flexeril and Norco. Advised her to go to the ER for IV pain medication to assist in alleviating pain, she declined.

05-31-11: Follow-up. CC: low back and bilateral leg pain. Claimant reported about 60% improvement in her pain particularly in the leg up until a few days ago when over the weekend; she began having significant increased back pain and now bilateral leg pain to about the level of the knees on each side. It is significantly worsened with any sort of activity. She went to the ER and was given

stronger hydrocodone and Tramadol which was not helping. She continues to take Flexeril 3 times a day and was given Dilaudid in the ER. She rated pain 10/10 and her brace increases her buttock pain. PE: Lumbar spine has diffuse discomfort to palpation up and down the lumbar spine. She has difficulty with mobility. She has multiple complaints to strength testing in the lower extremities all of which aggravates her low back pain. Her reflexes are symmetrically diminished bilaterally. DX: 1. Subacute low back pain with lower extremity radiculitis following surface fall at work, 2. Thoracolumbar pain with left-sided upper lumbar transverse process fractures, nondisplaced, 3. Lower rib contusion, 4. Grade 1 listhesis at L4-5 with displacement of the descending nerve root secondary to facet spur and ligamentum flavum protrusion, 5. Obesity. Plan: Reviewed symptoms of cauda equine syndrome and the emergency that would represent. She is currently having pain limitations and will improve her pain control with Butrans and continue Norco and Flexeril. Submit for second ESI and request a surgical consultation. The claimant is unable to work due to severe pain.

06-21-11: New Patient Consultation. Claimant has had PT, ESI x 2, and a trip to ER because of intractable persistent pain. Current pain 6/10. She has dysesthesias in an L5 distribution that has been alleviated substantially with a selective block that unfortunately was not long-lasting; second injection was not effective as the first. PE: Claimant favors left lower extremity with a mildly positive SLR. Dysesthsias again in an L5 distribution with diminished sensation to light touch and pinprick. She has absent Achilles reflexes bilaterally. EHL is graded 4/5 on the left. Impression: 1. Listhesis, 2. Radiculopathy, 3. Stenosis. Recommendations: Claimant has failed nonoperative care and inability to return to work, recommend a decompression and stabilization of the 4-5 segment to treat both her leg and back symptoms.

09-12-11: Operative Report. Preoperative Diagnoses: 1. Lumbar radiculopathy, 2. Spondylolisthesis at L4-5, 3. Stenosis. Postoperative Diagnoses: 1. Lumbar radiculopathy, 2. Spondylolisthesis at L4-5, 3. Stenosis

10-04-11: Follow-up. CC: first postop. Claimant stated she is overall doing well. She stated numbness in the left hip and groin but overall feels wonderful; her pain is definitely resolved. She still takes 1-1/2 hydrocodone three times a day and Flexeril 3 times a day but is decreasing as her pain is getting better. DX: stable postoperative course following XLIF and posterior fusion L4-5 on 9/12/11. Plan: return in 4 weeks, continue wearing brace, and continue with home health PT.

03-09-12: Follow-up. CC: postoperative check. Subjective: She is using a bone growth stimulator two hours a day. She still has pain that goes on her leg. Her leg pain aggravates her from sleeping. PE: She continued to have decreased sensation to the left anterior thigh and pain limits throughout the lower extremities. SLR reproduced her pain down to her legs to the front and the back of the legs bilaterally. DX: Continued lumbar radiculopathy s/p extreme lateral interbody fusion and posterior fusion at the L4-5 on 9/12/11. Plan: Recommend an EMG of

the lower extremities for the further investigation of her symptoms, discussed increasing Lyrica to 300mg per day.

07-10-13: Office Visit. CC: Incision check. Claimant stated about two weeks ago her incision opened up and has lesion to her back x 2 weeks and since the incision opened she now has pain around the incision and radiates to the right side. Current Medications: Metformin, Glipizide, aspirin, calcium citrate, vitamin D, losartan potassium-HCTZ, magnesium, naprelan. PE: There are surgical scars at the lumbar spine that are well healed. Left lumbar incision well healed no signs of dehiscence or infection. To the left of the incision two small healing lesions are noted smaller than a dime, mild erythema around wound edges but no exudates. Claimant reported tenderness upon hardware palpation. Assessment: stable post-op course s/p fusion L4-5 2011, acute low back pain possible hardware pain. Plan: Continue with compound cream prn pain, if failed will consider hardware block.

09-25-13: MRI Spine Lumbar w/wo Contrast. Impression: 1. Moderate central spinal stenosis at L3-4 as above. 2. 2-3 mm posterior disc osteophyte complex at T12-L1, L1-2, and L2-3 with mild effacement of the thecal sac. 3. Attempted anterior fusion at the L4-5 level with left pedicle screws at L4 and L5 also present. No central spinal stenosis or significant foraminal stenosis. 4. Mild marrow edema and enhancement anterior and T12 and L1 adjacent to the T12-L1 disc probably reactive to discogenic changes. No facture or bone destruction.

10-22-13: Office Visit. CC: back pain. Claimant continues to have low back pain that is aching and occasionally shoots into her posterior legs bilaterally for the past 5 months. She started wearing the back brace a few days ago which helped the pain. She does not take any pain medicine at home. She has slight weakness in her left leg, but has been present since before the surgery. PE: Paravertebral muscles are tender bilateral. Spinous processes are tender at the region. SLR are normal with left leg having discomfort at 85%. Assessment: stable post-op course s/p fusion L4-5 2011, L low back pain, healed wounds at the incision site. Plan: Flexeril at night to relieve the back pain and help with sleep, Recommend ESIs at the L3-4 level is the pain persists, F/U in one month.

11-22-13: Office Visit. CC: back pain and leg pain. Claimant stated that pain is worse and continues to have low back pain that is radiating down her left posterior left leg to the knee, and her left toe is also numb. PE: Paravertebral muscles are tender bilateral. Lumbar ROM is painful and restricted to the following: flexion painful at 75% of normal; extension is painful at 75% of normal; rotation on the right is painful at 75% of normal; rotation on the left is painful at 75% of normal. SLR is positive on the left side at 75 degrees. Left light touch is abnormal at L4, L5 and S1 dermatomes. Assessment: stable post-op course s/p fusion L4-5 2011, breakdown at L3-4, low back pain, and lumbar radiculopathy in the left leg. Plan: ESI left L3-4 with IV sedation, f/u 1 week after injection.

01-07-14: Office Visit. CC: left leg pain. Claimant stated after ESI her upper leg pain and low back pain is completely resolved and now has pain in the left leg

below the knee into her big toe. She stated her pain is burning and not sharp and stabbing like it was prior to the injection. EMG done 2 yrs ago is normal. PE: Paravertebral muscles are non-tender, with no evidence of spasm or trigger point. Left light touch is abnormal at L5 and S1 dermatomes. Assessment: stable post op course s/p fusion L4-5 2011, stenosis at L3-4, and lumbar radiculopathy in the left leg below the knee. Plan: Claimant stated the pain is manageable and changed since the injection, and the lower back pain is much improved. If pain worsens will do a decompression at L3-4. Claimant does not want to have another ESI because she stated was too painful.

10-22-14: Office Visit. CC: back pain and leg pain located on both left and right side. Claimant stated that a week ago she woke up from rolling over, and heard a crush in her back and had sharp pain. Since then she has had a lot of mid back pain and tenderness, pain in her low back that shoots down her lateral bilateral thighs, and wraps around to the front of the lower legs below the knee with weakness in the legs. PE: Paravertebral muscles are tender bilateral. Lumbar ROM is painful and restricted to the following: flexion painful at 50% of normal; extension is painful at 50% of normal; rotation on the right is painful at 50% of normal; rotation on the left is painful at 50% of normal. SLR is positive on the right and left side at 45 degrees. Left light touch is abnormal at L4, L5 and S1 dermatomes. Assessment: s/p fusion L4-5 2011, stenosis at L3-4, lumbar radiculopathy bilateral legs along the L4 and L5 dermatomes. Plan: Tramadol, Flexeril, Medrol dose pack. IF the pain is not improved in 1 week, recommend a lumbar CT myelogram to r/o any stenosis or HNP, F/U.

11-24-14: CT L-Spine w/o Contrast. Impression: 1. Postoperative changes from fusion at L4-5. Mild central canal stenosis. 2. Decreased disc height and vacuum disc at T12-L1. 2 mm disc bulge with mild impression on the anterior thecal sac. 3. 3 mm disc bulge at L1-2 with mild impression on the anterior thecal sac. 4. 5-6 mm right eccentric disc bulge at L2-3 with mild central canal stenosis and narrowing of the right lateral recese. Mild bilateral neuroforaminal narrowing. 5. 6 mm disc bulge at L3-4 eccentric to the right. Mild facet hypertrophy. Moderate central canal stenosis and narrowing of the right lateral recess. Mild to moderate right foraminal stenosis. Mild left foraminal stenosis. 6. Diverticulosis.

11-24-14: Myelogram L-Spine. Impression: There are postoperative changes from fusion at L4-5 with left pedicle screws, and stabilization lines and interbody fusion material. Myelogram contrast appears in the thecal sac.

12-09-14: Office Visit. CC: back pain and leg pain on both right and left sides. PE: Claimant is sitting uncomfortably with difficulty acquiring a full, upright position when getting out of the chair. Paravertebral muscles are tender bilateral. Lumbar ROM is painful and restricted to the following: flexion painful at 50% of normal; extension is painful at 50% of normal; rotation on the right is painful at 50% of normal; rotation on the left is painful at 50% of normal. SLR is positive on the right and left side at 45 degrees. Left and right light touch is abnormal at L4 and L5 dermatomes. Assessment: s/p fusion L4-5 2011, solid fusion L4-5, adjacent segment breakdown with stenosis at L3-4. Plan: Recommended ESI

L3-4 with IV sedation, RX for T3. New medications: cyclobenzaprine hcl 10mg, Tylenol with codeine #3.

01-14-15: Operative Report. Preoperative Diagnosis: Lumbar radiculopathy. Postoperative Diagnosis: Lumbar radiculopathy.

02-06-15: Office Visit. CC: follow-up visit. Claimant stated she is doing great. All of her radiculopathy down her legs has resolved and is no longer taking Tylenol #3. Assessment: s/p fusion L4-5 2011, stenosis at L3-4, lumbar radiculopathy bilateral legs – great results with L3-4 ESI. Plan: prn ESI L3-4 with IV sedation.

02-23-15: UR. Reason for denial: ODG states, "Radiculopathy must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing." Based on the clinical records submitted for review, the physical examination did not show any type of radicular findings. The CT of the lumbar noted at L3-4, decreased disc height 6 mm disc bulge eccentric to the right. Mild facet hypertrophy. Moderate central canal stenosis and narrowing of the right lateral recess. Mild to moderate right foraminal stenosis. Mild left foraminal stenosis. The guidelines also note, if after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. On 01/14/15, the claimant had L3-4 ESI. There is no documentation of 50-70% pain relief for at least 6-8 weeks with functional improvement noted from the previous injection. The request if not certified.

03-13-15: UR. Reason for denial: Based on the clinical information provided, the request for L3-4 ESI with IV injection is not recommended as medically necessary. The claimant's physical examination fails to establish the presence of active lumbar radiculopathy with negative straight leg raising and intact deep tendon reflexes, motor and sensation. The ODG requires documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted records fail to document at least 50% pain relief for at least 6 weeks after the most recent epidural steroid injection. There is no documentation of severe anxiety or needle phobia to support IV sedation. Not certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld and agreed upon. After reviewing the medical records and documentation provided, the claimant does not meet ODG guidelines for the requested ESI with IV sedation. There are no documented neurological signs such as reflex changes or atrophy to support the requested L3-4 ESI with IV sedation as the physical examination for the claimant does not document radiculopathy and furthermore, the previous injection did not show functional improvement with pain relief greater than 6-8 weeks. Therefore, the request L 3-4 Epidural Steroid Injection with IV sedation is denied.

Per ODG:

Epidural steroid injections (ESIs), therapeutic	**Criteria for the use of Epidural steroid injections:** *Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.* (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. (4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. -(5) No more than two nerve root levels should be injected using transforaminal blocks. (6) No more than one interlaminar level should be injected at one session. (7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007) (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. (9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment. (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**